TASK FORCE ON HEALTH SERVICES FOR THE ELDERLY

INTERIM REPORT B

PREVENTIVE HEALTH SERVICES FOR THE ELDERLY

June, 1990

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Presenters

Members of the Task Force on Health Services for the Elderly

Chair: Dr. Neena Chappell
Centre on Aging
University of Manitoba
338 Isbister Building
Winnipeg, Manitoba R3T 2N2

Members: Reverend Ralph Baxter
Ruperts Land Respite Care
168 Wilton
Winnipeg, Manitoba R3M 3C3

Ms. Dorothy Betz
829 Munroe Avenue
Winnipeg, Manitoba R2K 1J3

Mr. Jerry Hayes
614 Greene Avenue
Winnipeg, Manitoba R2K 0M6

Mr. Jack Kisil
Holy Family Home
165 Aberdeen
Winnipeg, Manitoba R2W 1T9

Ms. Beverly Kyle
Support Services To Seniors
Manitoba Health
302-333 Broadway
Winnipeg, Manitoba R3C 0S9

Ms. Dorothy Minish, R.N.
R.R. #1
Swan River, Manitoba R0L 0Z0

Ms. Lynne Mitchell-Pedersen, R.N.
Department of Geriatric Nursing
St. Boniface General Hospital
409 Tache Avenue
Winnipeg, Manitoba R2H 2A6

Dr. Colin Powell
Head, Department of Geriatric Medicine
St. Boniface General Hospital
409 Tache Avenue
Winnipeg, Manitoba R2H 2A6

Dr. James Thorsteinson
400 Tache Avenue
Winnipeg, Manitoba R2H 3E1

Ms. Gail Roth (MHSC Board Liaison)
Box 324
Miami, Manitoba R0G 1H0

Ms. Marguerite Chown (Steering Committee Liaison)
363 Lanark Street
Winnipeg, Manitoba R3N 1L5

List of Recommendations

Recommendation #1: The Health Advisory Network include in the mandate of the Health Promotion Task Force, the targeting of younger women for the prevention of osteoporosis as they become older.

Recommendation #2: A major effort be undertaken to educate and inform relevant health care professionals and paraprofessionals that remediable depression is a problem for a significant portion of elders, and to inform them about methods of recognition, and preventive approaches.

Recommendation #3: Appropriate therapeutic and social support be available for patients and relatives who may be suffering from depression.

Recommendation #4: The government establish valid and reliable information pages for the public, elders and their family members, as well as health care workers, on areas of concern such as osteoporosis, falls, and depression.

Recommendation #5: General practitioners be informed of the existence of comprehensive geriatric assessments for identifying those at risk of various pathologies and those conditions when referral is appropriate.

Recommendation #6: Research on pathologies of Manitoban elders which seeks to identify effective prevention approaches and age ranges in which prevention can be achieved be supported.

Recommendation #7: All departments of the Government of Manitoba adopt a perspective which portrays the importance of physical activity among elders. This includes both community-living elders and those in long-term care institutions.

Recommendation #8: Home Care reconsider its ban on homemakers from doing grocery shopping and assess various options for handling the money.

Recommendation #9: Discussions be held between groups of professional pharmacists and physicians concerning the particular needs of the elderly, including the topics of reassessment and minimizing the use of drugs.

Recommendation #10: Legislation ensure that, before drugs are made available, their effects on elders are examined.

Recommendation #11: That marketing information in relation to drugs include a warning that the dosage and indications may be different for elders.

Recommendation #12: The drug information codes be revised to include large print and better contrasting colours, then greater use be made of them.

Recommendation #13: The 55 Alive program expand discussion on substance abuse and the program receive more publicity.

Recommendation #14: The AFM be required to target services to elders that include active treatment as well as support.

Recommendation #15: The curricula for health care workers include information on alcoholism among elders.

Recommendation #16: Information be provided to elders and the general public concerning differential reactions to alcohol, age related changes in reactions to alcohol, and the proper use of alcohol.

Recommendation #17: Research be supported on the interventions which assist elderly alcoholics in their recovery.

Recommendation #18: The Elder Abuse Resource Centre be supported and monitored.

Recommendation #19: Manitoba devise legislation which protects abused adults, including abused elders. The legislation should include provision for guardianship of vulnerable adults.

Recommendation #20: Health care workers, elders, and the general public receive more information about elder abuse, its nature, its causes, and what action can be taken.

Recommendation #21: Research to understand the causes and solutions to elder abuse be undertaken.

Recommendation #22: Government, other relevant groups, and seniors meet to devise appropriate transportation services for frail elders, for social as well as health visits.

Recommendation #23: Barrier free environments be encouraged.

Recommendation #24: Recreational opportunities be available for Manitoban seniors.

TASK FORCE ON HEALTH SERVICES FOR THE ELDERLY
INTERIM REPORT B
PREVENTIVE HEALTH SERVICES FOR THE ELDERLY

Introduction

As already noted in Report A on Health Promotion, the Task Force on Health Services for the Elderly will be submitting several reports as it proceeds. This report is on preventive services, defined to deal specifically with health care services which are disease or condition specific. In this way they are distinguished from more general health promotion activities. This report focuses on non-communicable illness since communicable diseases are not a major cause of illness or death, especially among elders.

Although this report targets preventive services for elders, it is recognized that many of the important factors involved in prevention, such as lifestyles and all that they entail, are important throughout life. The Task Force on Health Services for the Elderly assumes the Health Promotion Task Force will examine illness prevention throughout the life span. This Task Force focuses only on elders.

As this report will discuss, it is wrong to assume that it is too late to take preventive behaviours seriously once one has reached old age. Many preventive strategies are discussed in this paper which can be targeted in the later years. Indeed, some people believe there is an advantage to focusing preventive measures in old age since elders may be more open to these endeavours than younger people. Elders are increasingly aware of the frailty of human aging.

This report is submitted in full recognition that our health care system responds best to patient initiated requests for help, and best to acute, usually reversible, disease. When one talks about prevention, and particularly

prevention in old age, one is discussing an area which has received little attention in our health care system. The very nomenclature for prevention derives largely from acute reversible disease and is not readily applicable to chronic, often irreversible pathology.

Prevention is classified as primary, secondary, or tertiary. Primary prevention seeks to diminish or remove those factors which make the onset of disease more likely. For example, stopping smoking reduces the risk of lung cancer; immunizations prevent some communicable diseases.

Secondary prevention includes both screening and case findings. Screening is intended to identify a disease process in the hope that it can be reversed. However, early identification does not necessarily mean the disease process can be arrested or reversed and it does not improve life expectancy. Case finding refers to the identification of a disease which may not be recognized or may be ignored by the individual patient. As with screening, case finding is of little value if no remediable intervention is available. Both screening and case finding are designed to shorten the course of the disease rather than prevent the individual from obtaining the disease. However, merely knowing about it longer is not necessarily beneficial and can cause considerable distress.

Tertiary prevention occurs after an individual has the disease and is seeking medical assistance. It is aimed at preventing the complications of the disease. An example would be the discovery and control of hypertension in preventing heart attacks and strokes. Early mobilization after hip fracture prevents pulmonary embolism, pressure sores, and contractures. Efforts to assist those with arthritis and rheumatism* are tertiary; they are aimed at minimizing disability.

This report is not exhaustive. It does not include every possible condition elders may experience. It highlights some of those which are particularly prevalent in old age and does so by establishing three targets for prevention: specific diseases or pathologies; lifestyle of the individual; and the health care system. For any action to be useful in this area, it is important to understand that prevention is multifaceted and frequently takes a long time before change will occur.

Specific Pathologies and Conditions

In this section, falls, osteoporosis, depression, stroke, and cancer, all common conditions among elders, are discussed. General recommendations applying to all of these areas are made at the end of the section.

Falls

Falls are a common problem facing frail elderly people at home and in institutional care. They cause both morbidity and mortality and are age-related. Falls can be caused by intrinsic factors such as postural hypotension or stroke and by extrinsic factors, essentially environmental factors such as hazards in the home or ice on the sidewalk. Elders age 75 and over who are housebound are at the greatest risk of falling. A comprehensive home assessment carried out, for example, by a trained public health nurse can identify both intrinsic and extrinsic factors. Extrinsic causes can be prevented through adequate lighting, adequate footwear, changing slippery and shiny floors, removing or changing loose

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* Arthritis and rheumatism will be dealt with in a later paper on treatment services.

rugs, having untippable bedside commodes, clearly marking stair edges, installing adequate hand supports, etc. For "recurrent fallers" and those most at risk using alarm systems such as the Victoria Hospital system and "fail safe" telephone calls from family and friends can provide tertiary prevention if a fall occurs.

Osteoporosis

Osteoporosis is an example where preventive strategies probably have to be enforced earlier in life. Perimenopausal osteoporosis can be diminished with judicious estrogen replacement therapy, exercise, and possibly attention to nutrition. Unfortunately, osteoporosis occurring ten or more years after menopause (senile osteoporosis) is not known to be amenable to prevention at this time. It reflects childhood nutrition and attainment of maximum bone density (approximately in the early 20s). Much attention is currently being given to calcium intake in relation to osteoporosis. It is known that calcium deficiency is related to osteoporosis but it has not been shown that calcium supplementation restores bone mass in senile osteoporosis. Known risk factors for fractures associated with osteoporosis include: white/oriental race, positive family history, thinness, artificial or early menopause, sedentary lifestyle, smoking, and excessive alcohol. Exercise, in particular low impact aerobics, has been shown to increase bone mass in women aged 45-70. Cortico steroids enhance osteoporosis and inappropriate use of steroids is another iatrogenic hazard facing the older woman. It is recommended that:

Recommendation #1: The Health Advisory Network include in the mandate of the Health Promotion Task Force, the targeting of younger women for the prevention of osteoporosis as they become older.

Depression

Most elders are not depressed and depression is not more prevalent in old age than in middle age. However, it is estimated that at least 10% of those over 65 living at home exhibit some features of depression. Depression is frequently misdiagnosed as anxiety or dementia, or attributed to associated physical illness or old age. Residents of institutions have a higher prevalence of depression, believed to be anywhere between 25% - 40%. Depression can be life threatening with death occurring either from suicide or inanition. However, depression is reversible in over 75% of subjects.

A main difficulty with depression is its lack of recognition. Some drugs, especially hypotensives, can cause depression. A past history of depression at any age is associated with a greater risk in old age. Physical illness, especially of a chronic, painful nature such as rheumatoid arthritis, can be a precipitating factor for depression. Sudden changes in health resulting in losses such as amputation, cancer or stroke are associated with depression. It is recommended that:

Recommendation #2: A major effort be undertaken to educate and inform relevant health care professionals and paraprofessionals that remediable depression is a problem for a significant portion of elders, and to inform them about methods of recognition, and preventive approaches.

Recommendation #3: Appropriate therapeutic and social support be available for patients and relatives who may be suffering from depression.

Stroke

For our purposes, a stroke is a focal lesion in the cerebrum resulting from impairment in vascular supply. When clinical features last less than 24 hours it is termed a transient ischemic attack (TIA). TIAs are risk factors for stroke. There are several etiological factors and a great variety of clinical presentations. It is unlikely that a single measure will prevent all types of stroke. Stroke can cause motor-sensory, communication, cognitive and affective deficits. Lower levels of arterial pressure (BP) are associated with less likelihood of stroke and other cardiovascular disease. The small decrease in BP resulting from weight control, cessation of smoking, exercise and dietary adjustments may produce significant diminution in strokes. Both pharmacological control of BP and lifestyle changes may well be a major cause of the decline in strokes in North America, but it is too soon to know. At this time there is little evidence that primary prevention in old age is of value in preventing strokes.

Cancer

Cancer is the uncontrollable growth of cells resulting from the loss or inactivation of normal control systems. Currently about one in three Canadians will develop cancer and one in four will die of it. Cancer of the lung, prostate and bowel in men and of breast, bowel and lung in women account for over half of cancer deaths. Changes in type and frequency of cancer over time and the tendency for cancer rates in immigrants towards that of their new country suggest a prominent role for modifiable factors, especially tobacco use and diet.

Cancer prevention in the elderly should be a continuation of an approach begun long before. Because many cancers appear to have a long latency, health

promoting behaviours should commence much earlier in life and be continued in later years. Specific prevention behaviours are few. Early diagnosis and treatment may "prevent" further progression of disease but opportunities for very early diagnosis are few.

The most important preventive effort for cancer reduction (and much other morbidity and mortality) is not to smoke or to be exposed to tobacco smoke. This may mean not commencing or stopping.

Societal and individual efforts to avoid exposure to other known carcinogens is prudent though the nature and toxic levels of these need much clarification. Of clearer benefit is an appropriate, balanced diet. Following dietary advice from authoritative sources is advised.

Overall Recommendations for Preventing Specific Pathologies and Conditions

There is no expert source for elders to obtain valid and reliable information on the latest fads, whether they be exercise fads or nutritional fads (Is calcium intake important to prevent osteoporosis? If it is, how much and in what form?). Part of information transmittal, awareness raising, and education includes the message that elders have the right to autonomy in decision-making about the care they receive and the level of care they receive.

In order to be effective, however, such information must not simply be displayed in health care workers' offices and mailed to the home. As far as we know, the most effective strategy for dissemination of such information is through community agencies which will ensure their discussion among community networks. Any programs targeted to this end must be appropriately evaluated with appropriate and realistic outcomes included in the measurement strategy.

All of the areas discussed here (falls, osteoporosis, depression, stroke, and cancer) can benefit from up-to-date valid and reliable information through research. It is recommended that:

Recommendation #4: The government establish valid and reliable information pages for the public, elders and their family members, as well as health care workers, on areas of concern such as osteoporosis, falls, and depression.*

Periodic assessment by a primary care health practitioner who is guided by up-to-date literature on the preventive strategies of proven merit is recommended. As well as guidance and assistance with the foregoing, a history which will search for other special risks of the individual, an appropriate physical exam, and a limited and tailored selection of laboratory/diagnostic tests is appropriate.

Counselling by an informed practitioner will focus on smoking avoidance, diet, the value of regular exercise, compliance with recommended investigations (eg., pap smear, mammography), skin protection from UV radiation, other individualized risk reduction, personal monitoring of changes in well-being and appropriate follow-up. Referral to other sources of information, including other practitioners, should be made as they may be of additional benefit to the individual. All of the areas discussed can also benefit from comprehensive geriatric assessments to identify those at risk.

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* The experience of the National Institutes on Aging in Bethesda, Maryland is instructive in this regard.

Recommendation #5: General practitioners be informed of the existence of comprehensive geriatric assessments for identifying those at risk of various pathologies and those conditions when referral is appropriate.

Recommendation #6: Research on pathologies of Manitoban elders which seeks to identify effective prevention approaches and age ranges in which prevention can be achieved be supported.

Individual Lifestyle Factors

The specific strategies discussed in this section refer to behaviours which individuals can themselves implement. In some instances they have been shown to be preventive for some of the diseases and conditions just discussed.

Exercise

Aging in our society has been regarded as a time of tranquility and well-deserved rest and it is highly correlated with a sedentary lifestyle. Inactivity is age-related with only 14% of men and 13% of women age 70 and over participating in some type of systematic exercise program four or more times per week (Cullen and Weeks, 1978). The harmful effects of that sedentary lifestyle are now being recognized. At least part of what we have attributed to changes due to age are not caused by age but by disuse. The old adage "use it or lose it" is being documented as true.

While research in this area is still incipient, cumulative evidence now suggests that regular physical exercise has many benefits, including increased aerobic capacity, increased muscle strength, increased joint range of movement and flexibility, improved neuromuscular coordination, decreased blood pressure, decreased risk of diabetes, decreased risk of osteoporosis, increased self-image,

improved body shape, increased independence in activities of daily living, increased emotional well-being, increased self-esteem, increased feelings of well-being, and decreased isolation. Even a minimal degree of movement and activity by those with physical limitations is believed to produce beneficial effects (Spirduso and Gilliam-MacRae, 1990; Blair et al., 1989). However, the benefits last only as long as it is practiced. Gains begin almost immediately upon onset of an exercise program but unfortunately losses occur almost immediately with cessation (Friese, 1990).

While certain precautions must be recognized, one is never too old to begin physical activity. There is dispute as to the value of extensive pre-exercise medical assessment, however, vigorous exercise may result in bony and soft tissue injury (eg., bending may precipitate osteoporotic vertebral crush fractures) or could accelerate osteoarthritis. Most agree that a doctor should approve a proposed program for elders. There is no consensus on whether the doctor's physical assessment should include a standard cardiovascular stress test. American authorities recommend this for all subjects; the British do not.

The Task Force applauds the decision of many of the swimming pools operated by Parks and Recreation to establish free swim times for seniors. However, they are urged to examine the times offered and to establish appropriate times. Many people, not the least of whom seniors, do not choose to swim at 6:00 a.m. on a Manitoba winter morning. It is noted that many privately run hotels and motels could establish time slots for seniors free of charge. The Task Force also applauds the mall walking program and recommends its expansion to the rural areas.

It is further noted that seniors groups currently provide and are encouraged to continue their advocacy for exercise for seniors. Participaction

is urged to utilize seniors in its commercials and other groups are also urged to utilize seniors in their advertising when it is targeted towards greater physical activity.

The Task Force recommends that:

Recommendation #7: All departments of the Government of Manitoba adopt a perspective which portrays the importance of physical activity among elders. This includes both community-living elders and those in long-term care institutions.

Nutrition

Far more is unknown about nutrition in old age than is known. Body weight does not change overall but constituents do, for example, lean body mass decreases and fat increases. One of the few undisputed gerontological facts is that calorie restriction, short of producing malnutrition, prolongs life expectancy.

The commonest form of malnutrition in our society is obesity which is associated with diabetes, osteoarthritis, hyperlipidaemias, some cancers, and probably hypertension. Certain diseases result from under-nutrition and occur in the elderly (eg., scurvy, osteoporosis, impairment of the immune function). The extent to which diet of Western industrialized society contributes to disease is not conclusive but increasingly it is thought that our high fat intake contributes to atheroma (hence heart attacks and strokes) and high salt intake contributes to hypertension. Some illnesses lead to malnutrition (eg., body protein stores fall with serious illness; depression leads to weight loss, Alzheimer dementia is associated with terminal inanition). It is too early to say how the cumulative effects of our preservative and additive fast food society

will be reflected in patterns of morbidity when the current generation of baby boomers becomes elderly.

Evidence of clinical malnutrition (where dietary deficiency or malabsorption of essential food stuffs results in detectable adverse effect on the person's health) among elders is rare, however most studies show that for most food stuffs elders do not receive the recommended dietary allowances (RDA). Attempts to restore below normal levels tend not to result in improvement.

We know little about the role of nutrition in quality of life and health of elders. However, the primary risk factors for malnutrition are poverty and low socio-economic status, social isolation, physical disability, ignorance about healthy diets, and dental problems. In our society, food is frequently associated as a reward from our very early years (the offering of treats for doing well or being good). It is also associated with social gatherings. Some elders, especially those widowed and living alone, no longer bother to prepare nutritious meals.

Barriers to adequate nutrition include inappropriate packaging, over-sized portions in restaurants, lack of opportunity for social eating, and lack of mobility for shopping. Programs such as congregate meals which offer inexpensive but nutritious meals, combined with a social aspect are recognized and should be continued. Similarly, several groups, both seniors groups and government now provide information about nutrition, how to prepare nutritional meals for one, etc. However, at the present time our Home Care program bans homemakers from doing grocery shopping because workers cannot handle money, although in the United Kingdom this is a major activity of homemakers (in the U.K. telephone and home deliveries are much less common). It is recommended that:

Recommendation #8: Home Care reconsider its ban on homemakers from doing grocery shopping and assess various options for handling the money.

The Health Care System

The third category for targeting preventive measures includes health care workers and the system within which they work.

Iatrogenesis

Iatrogenesis is a term coined by Illich (1976) for major threats to health caused by the medical establishment or the health care system. Iatrogenic disease has been termed "probably the most common preventable disease in old age" (Kane et al., 1985). Examples include sponges left in patients during operations, viruses picked up in the hospital, and dependency as a result of the type of care received in an institution.

Substance Abuse:

Problems caused through prescription drugs are a major concern for elders. Indeed, a major fear of old people is that they will be prescribed drugs inappropriately and excessively, that they will become like friends they know who were "overdrugged and zomboid". Inappropriate drug prescription for elders arises for several reasons: multiple pathology readily leads to multiple prescriptions; lack of understanding of the pharmacokinetic and pharmacodynamics of aging also leads to inappropriate prescribing (in one U.K. study drug induced illness was involved in 12% of admissions to geriatric units with nearly one-quarter having irreversible illness when the offending drugs were stopped) (Williamson and Chopin, 1980). Failure of communication often leads to poor

compliance with the prescription and there are particular problems associated with psychotropics (especially hypnotics and anxiolytics), hypertensives, and diuretics (for the ubiquitous swollen ankle). Information is usually received by doctors from pharmaceutical representatives whose job it is to sell the drug. Other more reliable sources of information are available. Pharmacists have a critical role to play with health care workers and elders today. The role of retail pharmacists in educating elderly Manitobans is encouraged. It is recommended that:

Recommendation #9: Discussions be held between groups of professional pharmacists and physicians concerning the particular needs of the elderly, including the topics of reassessment and minimizing the use of drugs.

In addition to inappropriate prescribing, there is the problem of double doctoring by patients to receive more medication. The Task Force supports the government's introduction of the triplicate prescription forms to control multiprescribing. Pharmaceutical companies are not required to undertake clinical trials in older subjects before releasing drugs commercially as is the requirement in some jurisdictions (such as Britain). The Task Force therefore recommends:

Recommendation #10: Legislation ensure that, before drugs are made available, their effects on elders are examined.

Recommendation #11: That marketing information in relation to drugs include a warning that the dosage and indications may be different for elders.

The drug information codes which currently exist are difficult for seniors to read. Seniors find large print and colour contrast the easiest to read. It is recommended that:

Recommendation #12: The drug information codes be revised to include large print and better contrasting colours, then greater use be made of them.

Recommendations from the Fourth Manitoba Conference on Aging, Fiction, Fact and the Future (1985), are supported by the Task Force. It is to be noted that the use of psychotropics in personal care homes is now monitored by the Prescription Guide Committee of MHSC which sets guidelines and standards for prescribing medications and other pharmaceutical practices and offers in-service programs to PCH staff. Because both seniors themselves as well as physicians and others working with elders require easily available information and education on drugs and the elderly, the Medical Information Line for the Elderly should receive secure support, should have a toll free telephone line, and should provide information in languages other than English. Local pharmacists and a pharmacy consultant from the Department of Health should provide consultation to the public, to physicians, to care facility staff and other health care professionals. More public information is needed in the use of the Pharmacare program.

While alcohol is not a prescription drug, it does epitomize a common problem in the health care of elders. The clinical presentation may markedly differ from that in younger adults. It may be misdiagnosed, it may be unrecognized or denied, and it may be regarded as untreatable. The clinical features may be attributed to concomitant disease. The prevalence of alcoholism

among elders is unknown although one Winnipeg study claims that elderly people attending a teaching hospital emergency department, exhibiting some evidence of substance abuse including both alcohol and prescription drugs, comprised one-third of the subjects (Tabisz and Jacyk, 1988). Chemical dependency on alcohol or drugs or both can be reliably detected among elders with appropriate measures and interventions. At the current time little is being done other than the demonstration project at St. Boniface and the Alcoholism Foundation of Manitoba (AFM) is starting to include elders in their programming. It is recommended that:

Recommendation #13: The 55 Alive program expand discussion on substance abuse and the program receive more publicity.

Recommendation #14: The AFM be required to target services to elders that include active treatment as well as support.

Recommendation #15: The curricula for health care workers include information on alcoholism among elders.

Recommendation #16: Information be provided to elders and the general public concerning differential reactions to alcohol, age related changes in reactions to alcohol, and the proper use of alcohol.

Recommendation #17: Research be supported on the interventions which assist elderly alcoholics in their recovery.

Elder Abuse

Elder abuse has become a topic of concern only recently. To date, rigorous research does not exist in this area and there are only guestimates available

on the prevalence of this problem. Age and Opportunity Inc. estimates that financial abuse is the most prevalent and family members are the most frequent abusers, usually in caregiving situations. At the present time in Manitoba there is no specific legislation or organization with a mandate or resources to deal with the problems of elder abuse, although we understand the Elder Abuse Resource Centre at the Age and Opportunity Centre has now been funded for a period of three years as an information centre. They are in urgent need of funding for a counsellor. Some provinces such as Prince Edward Island have legislation under the Adult Protection Act. The Task Force recommends that:

Recommendation #18: The Elder Abuse Resource Centre be supported and monitored.

Recommendation #19: Manitoba devise legislation which protects abused adults, including abused elders. The legislation should include provision for guardianship of vulnerable adults.

Recommendation #20: Health care workers, elders, and the general public receive more information about elder abuse, its nature, its causes, and what action can be taken.

Recommendation #21: Research to understand the causes and solutions to elder abuse be undertaken.

It is to be noted that a White Paper on Elder Abuse was released by the Manitoba Seniors Directorate, July, 1989. Public consultation is being sought on recommendations for government action. The Task Force applauds this effort but it notes the inappropriateness of a strategy which uses public town hall meetings as a forum for abused elders to come forward and discuss their plight.

The Task Force supports the recommendations of the Fourth Manitoba Conference on Aging's Fiction, Fact and the Future (1985) that public and professional education regarding abuse of elders be implemented.

Other Systems

Transportation

Part of the system within which elders live is the transportation system available within the province. For elders to remain a part of their community with access to family and friends, to health services, to education and recreational resources, a transportation system that is affordable, available and accessible is a necessity. Personal care homes and elderly persons housing facilities almost always offer van service to their residents for shopping, medical appointments, travelling, entertainment, etc.

Those living in their own homes in the community or non-specific apartment blocks, however, frequently lack adequate transportation services. In some smaller communities in rural Manitoba there are locally organized or volunteer drive programs. Within Winnipeg those sufficiently frail as to be unable to use the Winnipeg transit system either must use expensive taxi services or request the Handi Transit service. Handi transit, while costing the same as metro transit, requires booking several days ahead with no guarantee that the ride will be available on the day requested. It cannot handle emergencies. It appears to benefit the physically handicapped who go to work or to school or who are on a regular day program. Since a medical certificate is required to obtain a Handi Transit customer number, not all elders will wish to visit a family doctor when there is little likelihood they will be able to utilize this service for social reasons. The Task Force recommends:

Recommendation #22: Government, other relevant groups, and seniors meet to devise appropriate transportation services for frail elders, for social as well as health visits.

Related to the area of transportation is the broader area of personal mobility. Public buildings, shopping and entertainment centres, government and non-government offices, churches and parks have not become committed to the concept of a barrier free environment. Steps without handrails, ramps like ski slopes, public washrooms and elevators difficult for the physically frail to manage are all standard parts of these environments. Without barrier free environments it is difficult for elders to maintain an active and involved lifestyle that will help prevent isolation or decreases in emotional well-being. The Independent Living Resource Centre in Winnipeg asks why it is the physically handicapped must request a doctors certificate in order to receive various types of assistive devices which enable them to be mobile when those who are not physically handicapped do not have to do so. They argue that, in order to have control over their lives, these assistive devices must be available for them to choose the lifestyle which they are able to live. The Task Force recommends:

Recommendation #23: Barrier free environments be encouraged.

Recreation

Recreation is also a part of the system within which we live. The 1983 Interprovincial Recreation Committee of the Provincial Ministers Responsible for Sport and Recreation defined recreation as:

> All those things that a person or a group chooses to do in order to make their leisure time more interesting, more enjoyable, and more personally satisfying.

That is, recreation includes a wide range of pastimes including physical activities and mental activities. There is much we do not know about recreation and the role it plays in the lives of elders, but there is good reason to believe that the more involved elders are the healthier they are both physically and mentally. The Task Force recommends:

Recommendation #24: Recreational opportunities be available for Manitoban seniors.

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Note: Because the Task Force is submitting numerous reports, only documents and presenters most relevant to this report are listed here.